PUBLIC HEALTH UNIT INFECTION PREVENTION AND CONTROL LAPSE REPORT

Initial Report

Premise/facility under investigation (name and address)	Callander Bay Dental – A Dawson Family Practice 299 Main Street North, Callander, ON P0H 1H0
Type of premise/facility: (e.g., clinic, personal services setting)	Dental Office
Date Board of Health became aware of IPAC lapse	March 19, 2025
Date IPAC lapse was linked to the premise/facility	March 19, 2025
Date of Initial Report posting	April 3, 2025
Date of Initial Report update(s) (if applicable)	Not applicable
How the IPAC lapse was identified	Callander Bay Dental – A Dawson Family Practice
Summary Description of the IPAC Lapse	Improperly reprocessed reusable instruments used on clients.

IPAC Lapse Investigation

Did the IPAC lapse involve a member of a regulatory college?	Yes. • College of Dental Hygienists of Ontario • Royal College of Dental Surgeons of Ontario
If yes, was the issue referred to the regulatory college?	April 3, 2025
Were other stakeholders notified	Yes
Concise description of the corrective action required.	The dental clinic identified and notified the impacted clients about the IPAC lapse.
Please provide further details/steps	1. Along with the remedial measures already in place at the dental clinic, sterile packages must be inspected at the point of use to ensure they are not unsealed, damaged, wet, or visibly soiled, and that Chemical Indicators have not failed. 2. Reprocessing areas shall be made up of distinct and separate work areas based on the service provided and generally include areas for: • Receiving contaminated devices; • Decontamination of medical devices; • High-level disinfection if applicable; • Preparation and packaging; • Sterilization and storage. 3. The reprocessing area must have a one-way workflow of instruments with clear separation of dirty and clean sides to prevent contamination. A barrier (i.e., plexiglass) shall be installed to separate the decontamination area from the clean preparation and packaging area. 4. The electronic record for load record requirements shall be inspected at the conclusion of each cycle by the operator of the sterilizer. The operator shall confirm that the process parameters were met either by initialing the report (if printed) or by means of a password-protected entry (if electronic).

Final Report

Date of Final Report posting	May 7, 2025
Date any order(s) or directive(s) were issued to the owner/operator (if applicable)	March 25, 2025
Brief description of corrective measures taken	• Chemical indicators (CI) are checked to verify that the CIs had not failed when packages are removed from the sterilizer, prior placing the packages in sterile storage, upon removing the packages from sterile storage and at point of use prior to providing oral care to clients. **Complete** • A plexiglass barrier has been installed, separating the decontamination area from the clean preparation and packaging area. **Complete** • After each sterilization cycle, the electronic record for load requirements is reviewed to confirm that the necessary sterilization conditions were met within the chamber. The dental clinic is in the process of upgrading to a new data logger with more advanced technology. **Complete** • The dental clinic has obtained Manufacturer's Instructions for Use (MIFU) for motors that were in use. If a MIFU was not available, replacement motors with MIFUs were purchased. Motors are reprocessed in accordance with their MIFUs. **Complete**
Date all corrective measures were confirmed to have been completed	May 2, 2025

If you have any further questions, please contact:

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